

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E281		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/18/2011	
NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit resulted in an extended survey-immediate jeopardy.</p> <p>Survey dates: April 4-8, 2011 Extended survey dates: April 14-18, 2011</p> <p>Facility number: 000409 Provider number: 15E281 AIM number: 100291270</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN 4/4-8/11</p> <p>Census bed type: NF: 47 Total: 47</p> <p>Census payer type: Medicaid: 44</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	Other: 3 Total: 47  Sample: 12 Supplemental sample: 8  These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.  Quality review completed 3-25-11 Cathy Emswiller RN						

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F0156 SS=C	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>						

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	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p>						

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	<p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview, the facility failed to display written information concerning Medicare and Medicaid benefits. This had the potential to affect 47 of 47 residents residing in the facility.</p> <p>Finding includes:</p> <p>During observation on 4/8/11 which began at 11:00 a.m., with Maintenance staff #15, posting of information concerning Medicare and Medicaid information was not noted.</p> <p>During interview of the Social Service Designee [SSD] on, 4/8/11 at 3:00 p.m., the [SSD] indicated the facility did not have information concerning Medicare and Medicaid posting. The [SSD] was unable to provide a written policy concerning the posting.</p> <p>3.1-4(l)(1)</p>			F0156	<p>The corrective action accomplished for those residents found to have been affected by the deficient practice is the posting of information concerning Medicare and Medicaid and how to apply. Residents having the potential to be affected by the same deficient practice are all residents residing in the facility. Measures put into affect to ensure the practice does not recur is weekly observance of the bulletin board where the information is posted by the Social Services Director. The Social Services Director will monitor the bulletin board weekly to make sure the information is still posted. If not, she will replace the information posted. The Social Services Director will report findings at the monthly QA meeting.</p>		05/18/2011

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F0164 SS=D	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>			F0164	<p>The corrective accomplishment for this deficient practice will be to inservice all staff on privacy policy and procedure. Those residents identified to be affected by the deficient practice include all residents of the facility. All residents have the potential to be affected as all residents receive some type of personal care by staff. Steps to correct the deficient practice will be to inservice all</p>		05/18/2011

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	Based on observation and record review, the facility failed to provide personal				staff on privacy issues. Residents will be asked if they feel they have privacy at all times when ADLs and injections are done. Residents will be asked at the monthly resident council meetings with responses recorded. The corrective action will be monitored by the Administrator and DON who will review the responses made at the resident council meetings. Should there be a negative response, the DON shall speak with that resident and identify the area of lack of privacy. DON will then speak with the staff member identified as not following the policy and procedure and that staff member shall then be inserviced again. The residents will be asked about privacy for 2 consecutive meetings without a complaint regarding privacy issues, then at random meetings therefore. The DON and charge nurses shall be responsible to observe weekly for compromises in privacy issues by observing residents who cannot speak for themselves during ADL times. This weekly observation shall be random regarding resident and staff. Observations shall be documented and reported at monthly QA meetings times 2 months.		

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	<p>privacy to 1 of 1 resident observed during incontinence care in a sample of 12 and 3 of 4 residents observed receiving insulin injections in a sample of 12. [Residents #3, #21, #14 and #25]</p> <p>Findings include:</p> <p>1. On 4/5/11 at 11:20 a.m., CNAs #1 and #2 were observed to provide incontinence care to Resident #3. The resident was assisted to the bathroom of her bedroom. With the room door open to the hallway and bathroom door open, Resident #3 was assisted to stand in front of the sink in the bathroom. The resident's slacks and soiled incontinence brief were removed and incontinence care provided.</p>						

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	<p>2. On 4/6/11 at 11:15 a.m., LPN #3 was observed to provide an insulin injection to Resident #21. Resident #21 was observed in bed in her room, and the resident's roommate was observed seated in a chair on the opposite side of the room. Privacy was not maintained during administration of the medication as the privacy curtain was not pulled, and residents were in full view of each other.</p> <p>3. During medication pass on, 4/5/11 at 11:30 a.m., LPN #6 lifted the shirt of Resident #25 and provided an Insulin injection. The LPN did not pull the resident's privacy curtain and the resident's roommate was sitting on the side of his bed speaking with Resident</p>						

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	<p>#25.</p> <p>4. During medication pass on, 4/5/11 at 11:45 a.m., LPN #3 lifted the shirt of Resident #14 and provided an Insulin injection. The LPN did not pull the privacy curtain and the resident's roommate was sitting on the side of his bed facing Resident #14.</p> <p>A facility policy titled "Privacy," dated 7/10/05, provided by the DON on, 4/7/11 at 10:35 a.m., included, but was not limited to, "All residents have the right to privacy at all times. ...During care, privacy curtain and door to room to be closed. Grooming, bathing, nail care, (unless an activity) ...No invasive procedures to be done without privacy maintained:</p>						

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F0221 SS=D	<p>blood draws, fingersticks, eye drops, nose sprays, injections, G-Tube feedings/medication administration (PO [by mouth] meds may be administered in a group setting as long as meds are not discussed)...</p> <p>3.1-3(p)(2) 3.1-3(p)(4)</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to release the restraint at times outlined in the plan of care for 1 of 2 residents reviewed with physical restraints in a sample of 12. [Resident #3]</p> <p>Finding includes:</p> <p>On 4/6/11 at 5:00 p.m.,</p>			F0221	<p>The corrective action accomplished for this deficiency is inservicing staff on restraint use, especially on when to release the restraint. Those residents identified as having the potential to be affected by the deficient practice are those residents of the facility with restraint orders. Steps to correct the deficient practice will be to inservice nursing staff on policy of restraint use including releasing restraint. The corrective action will be monitored by the charge nurses and DON as they will observe residents in restraints during mealtimes and family visits and document that the restraint was released. If the resident is</p>		05/18/2011

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	<p>Resident #3 was observed in the dining room, in a wheelchair with a lap buddy restraint on being fed by LPN #12.</p> <p>On 4/5/11 at 10:20 a.m., Resident #3 was observed seated in a wheelchair with lap buddy on in lounge area. The resident's husband was seated next to the resident. On 4/5/11 at 11:15 a.m., Resident #3 was observed in the activity/dining room in a wheelchair with a lap buddy on.</p> <p>During observation of medication administration, LPN #6 asked Resident #3 if she was able to remove the lap buddy. Resident #3 appeared to understand the question but physically was unable to remove the device. During</p>				<p>restrained during mealtime, the staff member responsible for that resident will be inserviced again at that time. All physician orders were audited by the DON on April 28 and 29 for inaccurate orders. Physicians were notified of any incorrect orders and restraint orders are now correct on resident orders. The charge nurses and DON will be responsible for monitoring the corrective action daily for 2 months. If the deficiency is observed during the last month, the observations will be extended for another month, until one month is free of deficiencies. DON will report findings at the monthly QA meetings.</p>		

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	<p>interview at that time, LPN #6 indicated she had never known of the resident removing the device.</p> <p>Resident #3's clinical record was reviewed on 4/4/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to Huntington's Chorea.</p> <p>A Minimum Data Set [MDS] assessment, completed on 11/9/10 coded the resident as utilizing a restraint daily.</p> <p>A form titled "Restraint Audit Form," completed on 4/7/11, indicated the resident utilized a lap buddy restraint due to very little muscle control due to diagnosis of Huntington's Chorea. The form indicated bed and chair alarms had been tried as less restrictive methods</p>						

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	<p>which resulted in the resident getting up unassisted and staff unable to get to the resident quick enough which resulted in falls.</p> <p>A plan of care, dated 2/19/10 and updated 11/2/10 addressed the problem of "Resident uses Lap Buddy when up in wheel chair for personal safety." An approach included "Remove lap buddy during meals, activities, one on ones, and family visits."</p> <p>The most recent physician's recapitulation, signed by the physician 4/1/11 included the documentation of the resident utilizing a pelvic or soft posey restraint to prevent injury to self.</p> <p>On 4/7/11 at 3:10 p.m. the</p>						

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	DON was interviewed. The DON indicated a physician's order for the lap buddy was lacking.  3.1-26(b) 3.1-26(r)						

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F0225 SS=J	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report to the Administrator or</p>			F0225	<p>The corrective action accomplished for this deficiency includes the following: Inservicing of all employees on abuse as well as any new hires before they start work; initiating</p>		05/18/2011

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>DON immediately and investigate timely allegations of mistreatment expressed during Resident Council meetings for 2 of 7 months of council minutes reviewed and through staff interviews. [Residents #31, #11, #48, #45, #21, #18, and #44]</p> <p>This deficient practice resulted in Immediate Jeopardy. The immediate jeopardy was identified on 4/14/11 and began on 1/26/11. The Director of Nursing, Social Service Designee, and Administrator were notified of the Immediate Jeopardy on 4/14/11. The Immediate Jeopardy was removed on 4/18/11, but the facility remained out of compliance at the level of no actual harm with potential for more than minimal harm that is</p>				<p>an abuse reporting form for the reporting of allegations with inservicing of all staff on the new form; inservicing of activity director on reporting abuse and resident council notes by the social service consultant; monitoring of CNA's by the charge nurses for any abuse; and updating policies on resident council minutes to read "minutes will be given to administrator, DON, and department heads before the end of the day of the meeting." Residents having the potential to be affected by the deficient practice are all residents of the facility. Measures put into place to ensure the deficient practice does not recur include the inservicing of all employees on abuse, initiating an abuse reporting form, updating policy on reporting of resident council minutes. Skin assessments were done on all residents on April 14, 2011, with no suspicious or unknown findings. All alert and oriented residents were interviewed on April 14, 2011, regarding abuse or roughness by staff. Each month, a random selection of residents/families will be contacted by staff and asked about resident treatment. Interviews to be documented. The allegations toward the three CNA's (7, 9, and 13) were investigated and found to be unsubstantiated, however, all CNA's are no longer employed at this facility. Administrator and</p>		

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>not immediate jeopardy because on going in-service training of staff and new hires regarding implementation of new abuse reporting procedure will continue, as well as, continued monitoring to ensure policy is being followed. Investigation of allegations regarding CNAs #7, #9 and #13 to be completed and implementation of remedies dependant on outcome of investigations as well as reporting to ISDH outcome of investigations. Monitoring of the Activity Director in regard to reporting allegations immediately to the Administrator/DON and providing Resident Council Minutes to the Administrator, DON, and SSD, the day of the council meetings will continue by the Administrator and SSD.</p>				<p>Social Service director shall be responsible to make sure Resident's Council minutes are given to the administrator, DON, and department heads the day the meeting is held. Administrator will be responsible to see that all allegations of abuse are investigated IMMEDIATELY by him or his designee.</p>		

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>Additional training of the AD will continue with the Social Service Consultant. On going monitoring of residents through interviews of them or their representatives to be done on a monthly basis through a system of staff assigned to specific residents.</p> <p>Findings include:</p> <p>1. Resident council meeting minutes, were reviewed on 4/4/11 at 2:10 p.m. The minutes dated 1/26/11, included in new business: Resident #31 said he had complaints about CNAs #7, #9, and #13 loudly complaining it was not there job to clean residents' up when they had "s-t" all over themselves in front of Resident #31 and other residents. Resident #31</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>indicated CNA #7 called him a slob one day and "gets in peoples' faces" when talking to them and CNA #13 argues with him. The minutes indicated Residents #48 and #45 witnessed the same.</p> <p>Resident #48 no longer resides in the facility and Resident #45 was not able to be interviewed due to a cyclic event related to diagnoses of Schizoaffective disorder, Bipolar.</p> <p>The DON was interviewed on 4/4/11 at 3:00 p.m. The DON indicated she had not been made aware of the allegations from the meeting. The DON indicated it is the Activity Director [AD's] responsibility to report immediately to the Administrator/ DON any allegations expressed during</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>the council meetings, and minutes of the meeting are to be provided to the Administrator, DON and department heads no later than two days after the meeting. The DON indicated this was not being done.</p> <p>The Administrator was interviewed on 4/14/11 at 2:55 p.m. The Administrator indicated he had not been made aware of the allegations.</p> <p>2. The Resident council meeting minutes dated 2/22/11, reviewed on 4/4/11 at 2:10 p.m. included, but was not limited to, in new business, Resident #31 indicated things continue the same and he had seen a CNA make Resident #11 cry telling him he is a trouble maker over and over.</p>						

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	<p>On 4/5/11 at 10:15 a.m., the DON provided a report of an investigation she had done regarding the allegation of a CNA making Resident #11 cry. The report was, dated 2/28/11 and indicated a resident [not identified] brought the allegation to her attention six days after the resident council meeting.</p> <p>The investigative report documented interviews of Resident #11 and LPN #12. Resident #11 was questioned in general about staff treatment and was asked specifically if any staff members had made him cry. The resident indicated no. The resident was specifically asked about different staff members by name, and the resident</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>indicated no.</p> <p>During an interview with the DON on 4/5/11 at 10:15 a.m., the DON indicated she interviewed LPN #12 as she provides restorative services and spends most of day in the open common area where Resident #11 spends most of the time. The LPN indicated the resident had been removed from in front of the television one time as was repeatedly stating "help" and disrupting other residents watching a television show and the resident began crying. The LPN indicated she had not witnessed any kind of abusive or inappropriate treatment of the resident.</p> <p>On 4/14/11 at 3:05 p.m., Resident #31 was interviewed.</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>The resident indicated the CNA who made Resident #11 cry was CNA #7. Resident #31 indicated the CNA was repeatedly telling Resident #31 he was diabetic and the resident became upset and was crying. Resident #31 indicated he had not been interviewed regarding the incident.</p> <p>Resident #31's clinical record was reviewed on 4/8/11 at 2:00 p.m. The Minimum Data Set [MDS] assessment, completed on 2/22/11 coded the resident with no cognitive or memory problems.</p> <p>Resident #11 was interviewed on 4/14/11 at 3:20 p.m. The resident indicated everything was fine.</p> <p>Resident #11's clinical record</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>was reviewed on 4/15/11 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, personality disorder, obsessive/compulsive disorder and major depression. The most recent Minimum Data Set [MDS] assessment, with assessment reference date of 3/1/11 coded the resident with a score of 12 [moderate impairment].</p> <p>3. On 4/14/11 staff members were interviewed beginning at 1:00 p.m. CNA #5 indicated Resident #18 had voiced a concern of CNAs #7 and #13 [2 of 3 CNAs identified in January Resident Council meeting] being rough during care. CNA #5 indicated the resident reported it to her shortly after the CNAs began</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>employment in the facility [November, 2010]. The CNA indicated you would report this to the nurse, but could not remember if she had.</p> <p>4. CNA #1 was interviewed. The CNA indicated she had reported several times that CNA #17, who only works weekends, was rough when providing care. The CNA indicated she had reported it to the nurse, and the nurse dealt with it.</p> <p>CNA #1 also indicated she thinks CNA #9 [1 of 3 CNAs identified in January Resident Council meeting] is rough during care, and was rough when transferring Resident #8 from the wheelchair to geri-chair.</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>5. CNA #8 indicated he was working with CNA #7 and Resident #21 requested he cleanse her skin during care, as CNA #7 was too rough.</p> <p>Resident #21 was interviewed on 4/14/11 at 3:15 p.m. and indicated she had no concerns with staff treatment or care issues.</p> <p>On 4/17/11 at 3:40 p.m. the DON provided documentation of an interview completed with Resident #21 on 4/14/11. Resident #21 indicated CNA #7 had been rough once when he was cleaning her up, but did not do it deliberately. The resident pointed it out, it stopped and has been okay since then. "He is too much of a muscle man, doesn't know his own strength."</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>CNA #8 also indicated Resident #18 did not like CNA #7 to transfer her as he was too rough. He believed it was about 2 to 3 weeks ago and he thinks he had reported it to a nurse.</p> <p>The documentation of the DON's resident interviews completed on 4/14/11 included interview of Resident #18. The interview, included but was not limited to, CNA #7 "has put me in bed too hard when he has transferred me."</p> <p>6. CNA #9 was interviewed. The CNA indicated CNA #7 was rough with certain residents and named Residents #44, #40, and doesn't like Resident #46. CNA #9 indicated Resident #46 was very afraid of spiders and bugs</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>and CNA #7 would get close to his face and tell the resident the bugs would get on his face and in his mouth when he was sleeping. The CNA indicated Resident #46 looked frightened and ran away. The CNA indicated the incident occurred in January and the resident refused to sleep in his room for four nights and slept in another room.</p> <p>The DON was interviewed on 4/14/11 at 4:00 p.m. The DON indicated she was aware Resident #46 was afraid of bugs and CNA #7 had stripped the resident's bed and "gone through the motions of spraying the room for bugs" in an attempt to relieve the resident's fear. The DON indicated she was not aware of any allegation of staff trying to</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>scare the resident.</p> <p>Resident #46's clinical record was reviewed on 4/15/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, chronic mood disorder, chronic encephalopathy from traumatic brain injury and hallucinations.</p> <p>A nurse's note dated 2/11/11 at 6:00 a.m. was noted of Res [resident] has been awake most of noc [night,] is convinced that there are spiders in Res bed- have tried to get him to sleep in another room without success." A nurse's note dated 2/11/11 7 am-7 p.m. indicated the resident continued saying there were spiders everywhere. The resident's room was cleaned even the resident helped but the resident</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>continued saying there were spiders everywhere.</p> <p>A nursing note dated 2/12/11 at 6:00 p.m. was noted of "Res [resident] has continuously talked about spiders all day. He has stomped on imaginary spiders, picked them off of himself, flipped them across the table. Ran fast up to the nurses' station and said the spiders were going to his heart. Can reorient res after a time and it will last for a short while." Documentation of the behavior regarding spiders was continued on nurses' notes dated 2/13/11 and 2/14/11. Documentation on 2/15/11 at 6:00 a.m. indicated the resident walked the halls until 3:00 a.m. at that time he said there were "bugs, bugs, bugs in his bed." Went down on East and got in</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>other bed, slept until 5:00 a.m.</p> <p>CNA #9 indicated CNA #7 "deliberately yanks" the lift sling out from under Resident #44 which resulted in a skin tear to the left elbow two months ago.</p> <p>The CNA indicated the Administrator and DON had been notified of incidents, but "everyone" stopped reporting in January because the Administrator and DON weren't doing anything.</p> <p>The DON was interviewed on 4/14/11 at 4:00 p.m. The DON indicated she did not know of any skin tears to Resident #44 and the resident was assessed by wound doctor weekly.</p> <p>Resident #44 was interviewed</p>						

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	<p>on 4/15/11 at 3:00 p.m. and indicated he did not have any concerns with the way he was treated.</p> <p>Resident #44's clinical record was reviewed on 4/15/11 at 10:53 a.m. A Minimum Data Set [MDS] assessment, with assessment reference date of 2/8/11 coded the resident with no memory or cognitive impairments and required total assistance of two for transfers and total assistance of one for hygiene/bathing.</p> <p>On 4/14/11 at 4:10 p.m., the DON provided documentation of Inservice Training Class Report, dated 12/31/10 for "Treating Residents with Respect Treating Co-Workers with Respect, Reporting Abuse." A pre and post test</p>						

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	<p>sample provided with the attendance sheet addressed "Treating Residents With Respect," and reporting abuse immediately to the charge nurse. Review of the inservice documentation indicated CNAs #8, #5, #1, and #9 attended the in-service. Documentation of the AD attending was lacking.</p> <p>On 4/7/11 at 12:30 p.m., the [AD] Activity Director, responsible for taking minutes in the Resident council meetings, indicated she makes copies of the meetings' minutes and gives one to the DON, the SSD [Social Service Designee] and puts a copy in a book of council minutes. The AD indicated it is not done immediately, but usually a couple of days later.</p> <p>The facility's policy titled "Abuse Policy," [no</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>date] reviewed on 4/5/11 at 10:15 a.m. included, but was not limited to, "Staff to Resident Abuse Policy: 1.) The following persons shall immediately be notified: supervisor of staff person suspected of being involved, The Director of Nursing and/or Administrator, Attending Physician, and family or responsible party of resident. The Indiana State Board of Health shall be notified within 24 hours. 4.) During the period of time in which the in house investigation is being done, the alleged involved staff member will be temporarily suspended from duty pending the outcome of said investigation. 5.) At the conclusion of the investigation, the time frame of which is not to exceed 72 hours, the Indiana State Board of Health will be notified of results, as will be the involved persons. ..."</p> <p>A policy titled "Policy and Procedure for Resident's Council, dated 6/20/10, provided by the DON on 4/5/11 at 10:15 a.m., included, but not limited to, "The minutes shall be given to the administrator, DON, and department heads no later than 2 days following the meeting. Any allegations of mistreatment or abuse shall be reported immediately to the administrator/department head."</p> <p>An Immediate Jeopardy was identified on 4/14/11 at 2:30 p.m. The Immediate Jeopardy began on 1/26/11 in that the facility failed to report allegations of verbal abuse</p>						

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	<p>expressed during Resident Council meetings immediately to the Administrator/DON and through staff interviews allegations regarding rough treatment during care and intimidation were not reported immediately to the Administrator/DON and investigations done or thoroughly investigated. The Administrator, DON, and SSD were notified of the Immediate Jeopardy on 4/14/11 at 2:30 p.m. related to failure to report allegations of verbal abuse immediately to the Administrator/DON and investigations done, or thoroughly investigated.</p> <p>The Immediate Jeopardy was removed on April 18, 2011, at 3:30 p.m., when through observations, interview and</p>						

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	<p>record review it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Through observation, 2 of 3 CNAs with allegations of verbal abuse or rough handling were suspended pending investigation and 1 of 3 CNAs, on days worked, was monitored by assigned nurses pending completion of investigation. Nurses were assigned shifts for continued monitoring of all staff as well as the DON. A new policy regarding abuse reporting to ensure allegations are reported immediately to the Administrator/DON was developed and inservice training started on 4/18/11. The Activity Director was</p>						

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	<p>in-serviced regarding the Abuse policy and procedure, as well as training regarding providing Resident Council Minutes to the Administrator, DON, and SSD, the day of the meetings. A Social Service Consultant began additional training of the AD on 4/18/11. All staff were re-inserviced regarding the facility's abuse policies and procedures. Even though the facility's corrective action removed the IJ, the facility remained out of compliance at a reduced scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-28(c) 3.1-28(d))</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2011

FORM APPROVED

OMB NO. 0938-0391

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F0226 SS=J	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  Based on interview and record review, the facility failed to report to the Administrator or DON immediately and investigate timely allegations of mistreatment expressed			F0226	The corrective action accomplished for this deficiency includes the following: Inservicing of all employees on abuse as well as any new hires before they start work; initiating an abuse reporting form for the reporting of allegations with inservicing of all staff on the new form; inservicing of activity director on reporting abuse and		05/18/2011

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	<p>during Resident Council meetings for 2 of 7 months of council minutes reviewed and through staff interviews. [Residents #31, #11, #48, #45, #21, #18, and #44]</p> <p>This deficient practice resulted in Immediate Jeopardy. The immediate jeopardy was identified on 4/14/11 and began on 1/26/11. The Director of Nursing, Social Service Designee, and Administrator were notified of the Immediate Jeopardy on 4/14/11. The Immediate Jeopardy was removed on 4/18/11, but the facility remained out of compliance at the level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because on going in-service training of staff and new hires</p>				<p>resident council notes by the social service consultant; monitoring of CNA's by the charge nurses for any abuse; and updating policies on resident council minutes to read "minutes will be given to administrator, DON, and department heads before the end of the day of the meeting." Residents having the potential to be affected by the deficient practice are all residents of the facility. Measures put into place to ensure the deficient practice does not recur include the inservicing of all employees on abuse, initiating an abuse reporting form, updating policy on reporting of resident council minutes. Skin assessments were done on all residents on April 14, 2011, with no suspicious or unknown findings. All alert and oriented residents were interviewed on April 14, 2011, regarding abuse or roughness by staff. Each month, a random selection of residents/families will be contacted by staff and asked about resident treatment. Interviews to be documented. The allegations toward the three CNA's (7, 9, and 13) were investigated and found to be unsubstantiated, however, all CNA's are no longer employed at this facility. Administrator and Social Service director shall be responsible to make sure Resident's Council minutes are given to the administrator, DON, and department heads the day</p>		

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	regarding implementation of new abuse reporting procedure will continue, as well as, continued monitoring to ensure policy is being followed. Investigation of allegations regarding CNAs #7, #9 and #13 to be completed and implementation of remedies dependant on outcome of investigations as well as reporting to ISDH outcome of investigations. Monitoring of the Activity Director in regard to reporting allegations immediately to the Administrator/DON and providing Resident Council Minutes to the Administrator, DON, and SSD, the day of the council meetings will continue by the Administrator and SSD. Additional training of the AD will continue with the Social Service Consultant. On going				the meeting is held. Administrator will be responsible to see that all allegations of abuse are investigated IMMEDIATELY by him or his designee.		

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	<p>monitoring of residents through interviews of them or their representatives to be done on a monthly basis through a system of staff assigned to specific residents.</p> <p>Findings include:</p> <p>1. Resident council meeting minutes, were reviewed on 4/4/11 at 2:10 p.m. The minutes dated 1/26/11, included in new business: Resident #31 said he had complaints about CNAs #7, #9, and #13 loudly complaining it was not there job to clean residents' up when they had "s-t" all over themselves in front of Resident #31 and other residents. Resident #31 indicated CNA #7 called him a slob one day and "gets in peoples' faces" when talking to</p>						

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	<p>them and CNA #13 argues with him. The minutes indicated Residents #48 and #45 witnessed the same.</p> <p>Resident #48 no longer resides in the facility and Resident #45 was not able to be interviewed due to a cyclic event related to diagnoses of Schizoaffective disorder, Bipolar.</p> <p>The DON was interviewed on 4/4/11 at 3:00 p.m. The DON indicated she had not been made aware of the allegations from the meeting. The DON indicated it is the Activity Director [AD's] responsibility to report immediately to the Administrator/ DON any allegations expressed during the council meetings, and minutes of the meeting are to be provided to the</p>						

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	<p>Administrator, DON and department heads no later than two days after the meeting. The DON indicated this was not being done.</p> <p>The Administrator was interviewed on 4/14/11 at 2:55 p.m. The Administrator indicated he had not been made aware of the allegations.</p> <p>2. The Resident council meeting minutes dated 2/22/11, reviewed on 4/4/11 at 2:10 p.m. included, but was not limited to, in new business, Resident #31 indicated things continue the same and he had seen a CNA make Resident #11 cry telling him he is a trouble maker over and over.</p> <p>On 4/5/11 at 10:15 a.m., the DON provided a report of an</p>						

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	<p>investigation she had done regarding the allegation of a CNA making Resident #11 cry. The report was, dated 2/28/11 and indicated a resident [not identified] brought the allegation to her attention six days after the resident council meeting.</p> <p>The investigative report documented interviews of Resident #11 and LPN #12. Resident #11 was questioned in general about staff treatment and was asked specifically if any staff members had made him cry. The resident indicated no. The resident was specifically asked about different staff members by name, and the resident indicated no.</p> <p>During an interview with the</p>						

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	<p>DON on 4/5/11 at 10:15 a.m., the DON indicated she interviewed LPN #12 as she provides restorative services and spends most of day in the open common area where Resident #11 spends most of the time. The LPN indicated the resident had been removed from in front of the television one time as was repeatedly stating "help" and disrupting other residents watching a television show and the resident began crying. The LPN indicated she had not witnessed any kind of abusive or inappropriate treatment of the resident.</p> <p>On 4/14/11 at 3:05 p.m., Resident #31 was interviewed. The resident indicated the CNA who made Resident #11 cry was CNA #7. Resident #31</p>						

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	<p>indicated the CNA was repeatedly telling Resident #31 he was diabetic and the resident became upset and was crying. Resident #31 indicated he had not been interviewed regarding the incident.</p> <p>Resident #31's clinical record was reviewed on 4/8/11 at 2:00 p.m. The Minimum Data Set [MDS] assessment, completed on 2/22/11 coded the resident with no cognitive or memory problems.</p> <p>Resident #11 was interviewed on 4/14/11 at 3:20 p.m. The resident indicated everything was fine.</p> <p>Resident #11's clinical record was reviewed on 4/15/11 at 1:00 p.m. The resident's diagnoses included, but were</p>						

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	<p>not limited to, dementia, personality disorder, obsessive/compulsive disorder and major depression. The most recent Minimum Data Set [MDS] assessment, with assessment reference date of 3/1/11 coded the resident with a score of 12 [moderate impairment].</p> <p>3. On 4/14/11 staff members were interviewed beginning at 1:00 p.m. CNA #5 indicated Resident #18 had voiced a concern of CNAs #7 and #13 [2 of 3 CNAs identified in January Resident Council meeting] being rough during care. CNA #5 indicated the resident reported it to her shortly after the CNAs began employment in the facility [November, 2010]. The CNA indicated you would report this</p>						

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	<p>to the nurse, but could not remember if she had.</p> <p>4. CNA #1 was interviewed. The CNA indicated she had reported several times that CNA #17, who only works weekends, was rough when providing care. The CNA indicated she had reported it to the nurse, and the nurse dealt with it.</p> <p>CNA #1 also indicated she thinks CNA #9 [1 of 3 CNAs identified in January Resident Council meeting] is rough during care, and was rough when transferring Resident #8 from the wheelchair to geri-chair.</p> <p>5. CNA #8 indicated he was working with CNA #7 and Resident #21 requested he</p>						

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	<p>cleanse her skin during care, as CNA #7 was too rough.</p> <p>Resident #21 was interviewed on 4/14/11 at 3:15 p.m. and indicated she had no concerns with staff treatment or care issues.</p> <p>On 4/17/11 at 3:40 p.m. the DON provided documentation of an interview completed with Resident #21 on 4/14/11. Resident #21 indicated CNA #7 had been rough once when he was cleaning her up, but did not do it deliberately. The resident pointed it out, it stopped and has been okay since then. "He is too much of a muscle man, doesn't know his own strength."</p> <p>CNA #8 also indicated Resident #18 did not like CNA</p>						

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	<p>#7 to transfer her as he was too rough. He believed it was about 2 to 3 weeks ago and he thinks he had reported it to a nurse.</p> <p>The documentation of the DON's resident interviews completed on 4/14/11 included interview of Resident #18. The interview, included but was not limited to, CNA #7 "has put me in bed too hard when he has transferred me."</p> <p>6. CNA #9 was interviewed. The CNA indicated CNA #7 was rough with certain residents and named Residents #44, #40, and doesn't like Resident #46. CNA #9 indicated Resident #46 was very afraid of spiders and bugs and CNA #7 would get close to his face and tell the resident the bugs would get on his face and</p>						

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	<p>in his mouth when he was sleeping. The CNA indicated Resident #46 looked frightened and ran away. The CNA indicated the incident occurred in January and the resident refused to sleep in his room for four nights and slept in another room.</p> <p>The DON was interviewed on 4/14/11 at 4:00 p.m. The DON indicated she was aware Resident #46 was afraid of bugs and CNA #7 had stripped the resident's bed and "gone through the motions of spraying the room for bugs" in an attempt to relieve the resident's fear. The DON indicated she was not aware of any allegation of staff trying to scare the resident.</p> <p>Resident #46's clinical record</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E281		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2011	
NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>was reviewed on 4/15/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, chronic mood disorder, chronic encephalopathy from traumatic brain injury and hallucinations.</p> <p>A nurse's note dated 2/11/11 at 6:00 a.m. was noted of Res [resident] has been awake most of noc [night,] is convinced that there are spiders in Res bed- have tried to get him to sleep in another room without success." A nurse's note dated 2/11/11 7 am-7 p.m. indicated the resident continued saying there were spiders everywhere. The resident's room was cleaned even the resident helped but the resident continued saying there were spiders everywhere.</p>						

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	<p>A nursing note dated 2/12/11 at 6:00 p.m. was noted of "Res [resident] has continuously talked about spiders all day. He has stomped on imaginary spiders, picked them off of himself, flipped them across the table. Ran fast up to the nurses' station and said the spiders were going to his heart. Can reorient res after a time and it will last for a short while." Documentation of the behavior regarding spiders was continued on nurses' notes dated 2/13/11 and 2/14/11. Documentation on 2/15/11 at 6:00 a.m. indicated the resident walked the halls until 3:00 a.m. at that time he said there were "bugs, bugs, bugs in his bed." Went down on East and got in other bed, slept until 5:00 a.m.</p> <p>CNA #9 indicated CNA #7</p>						

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	<p>"deliberately yanks" the lift sling out from under Resident #44 which resulted in a skin tear to the left elbow two months ago.</p> <p>The CNA indicated the Administrator and DON had been notified of incidents, but "everyone" stopped reporting in January because the Administrator and DON weren't doing anything.</p> <p>The DON was interviewed on 4/14/11 at 4:00 p.m. The DON indicated she did not know of any skin tears to Resident #44 and the resident was assessed by wound doctor weekly.</p> <p>Resident #44 was interviewed on 4/15/11 at 3:00 p.m. and indicated he did not have any concerns with the way he was</p>						

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	<p>treated.</p> <p>Resident #44's clinical record was reviewed on 4/15/11 at 10:53 a.m. A Minimum Data Set [MDS] assessment, with assessment reference date of 2/8/11 coded the resident with no memory or cognitive impairments and required total assistance of two for transfers and total assistance of one for hygiene/bathing.</p> <p>On 4/14/11 at 4:10 p.m., the DON provided documentation of Inservice Training Class Report, dated 12/31/10 for "Treating Residents with Respect Treating Co-Workers with Respect, Reporting Abuse." A pre and post test sample provided with the attendance sheet addressed "Treating Residents With</p>						

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	<p>Respect," and reporting abuse immediately to the charge nurse. Review of the inservice documentation indicated CNAs #8, #5, #1, and #9 attended the in-service. Documentation of the AD attending was lacking.</p> <p>On 4/7/11 at 12:30 p.m., the [AD] Activity Director, responsible for taking minutes in the Resident council meetings, indicated she makes copies of the meetings' minutes and gives one to the DON, the SSD [Social Service Designee] and puts a copy in a book of council minutes. The AD indicated it is not done immediately, but usually a couple of days later.</p> <p>The facility's policy titled "Abuse Policy," [no date] reviewed on 4/5/11 at 10:15 a.m. included, but was not limited to, "Staff to Resident Abuse Policy: 1.) The following persons shall immediately be notified:</p>						

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p><b>supervisor of staff person suspected of being involved, The Director of Nursing and/or Administrator, Attending Physician, and family or responsible party of resident. The Indiana State Board of Health shall be notified within 24 hours. 4.) During the period of time in which the in house investigation is being done, the alleged involved staff member will be temporarily suspended from duty pending the outcome of said investigation. 5.) At the conclusion of the investigation, the time frame of which is not to exceed 72 hours, the Indiana State Board of Health will be notified of results, as will be the involved persons. ..."</b></p> <p><b>A policy titled "Policy and Procedure for Resident's Council, dated 6/20/10, provided by the DON on 4/5/11 at 10:15 a.m., included, but not limited to, "The minutes shall be given to the administrator, DON, and department heads no later than 2 days following the meeting. Any allegations of mistreatment or abuse shall be reported immediately to the administrator/department head."</b></p> <p><b>An Immediate Jeopardy was identified on 4/14/11 at 2:30 p.m. The Immediate Jeopardy began on 1/26/11 in that the facility failed to report allegations of verbal abuse expressed during Resident Council meetings immediately to the Administrator/DON and</b></p>						

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	<p>through staff interviews allegations regarding rough treatment during care and intimidation were not reported immediately to the Administrator/DON and investigations done or thoroughly investigated. The Administrator, DON, and SSD were notified of the Immediate Jeopardy on 4/14/11 at 2:30 p.m. related to failure to report allegations of verbal abuse immediately to the Administrator/DON and investigations done, or thoroughly investigated.</p> <p>The Immediate Jeopardy was removed on April 18, 2011, at 3:30 p.m., when through observations, interview and record review it was determined that the facility had implemented the plan of action</p>						

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	<p>to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Through observation, 2 of 3 CNAs with allegations of verbal abuse or rough handling were suspended pending investigation and 1 of 3 CNAs, on days worked, was monitored by assigned nurses pending completion of investigation. Nurses were assigned shifts for continued monitoring of all staff as well as the DON. A new policy regarding abuse reporting to ensure allegations are reported immediately to the Administrator/DON was developed and inservice training started on 4/18/11. The Activity Director was in-serviced regarding the Abuse policy and procedure, as well as training regarding providing</p>						

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	<p>Resident Council Minutes to the Administrator, DON, and SSD, the day of the meetings. A Social Service Consultant began additional training of the AD on 4/18/11. All staff were re-inserviced regarding the facility's abuse policies and procedures. Even though the facility's corrective action removed the IJ, the facility remained out of compliance at a reduced scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-28(a)</p>						

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F0253 SS=D	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure resident equipment was maintained in that 2 of 2 geri-chairs and 2 of 3 lap buddies observed were either ripped or had bent frames. [Residents #9, #42, and #8]</p> <p>Findings include:</p> <p>1. During environmental tour</p>			F0253	<p>The corrective action accomplished for this deficiency is that 2 new geri-chairs and 3 lap buddies will be ordered to replace the damaged ones. Those residents having the potential to be affected by the deficient practice are identified as those residents who use a geri-chair or lap buddy. Measures put into place to ensure the deficient practice does not recur is staff will be inserviced on monitoring geri-chairs and lap buddies for wear and damage and how to report to maintenance if repairs are needed. Maintenance will inspect geri-chairs weekly and document findings and report to administrator when repairs/replacements are</p>		05/18/2011

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>with the Maintenance staff #15 on 4/8/11 at 11:00 a.m. Resident #9's geri-chair was observed with a crooked foot rest. Maintenance staff #15 looked under the chair and during interview at that time indicated the metal frame to the foot rest was bent. On 4/4/11 at 12:00 p.m., Resident #9 was observed in the chair, in the dining room, and for the footrest to be slanting to the right.</p> <p>2. During observation of care on 4/5/11 at 10:20 p.m., Resident #42 was placed in a geri-chair. The foot rest of the chair was observed to be crooked and when in a down position would not close all the way. The vinyl was torn on one corner of the seat cushion, exposing a white foam interior.</p>				<p>needed. Administrator will be responsible for geri-chair replacement/repairs and DON will be responsible for replacement of damaged lap buddies.</p>		

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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F0315 SS=D	<p>Heavy dust was noted on the interior back base of the geri-chair.</p> <p>3. On 4/6/11 at 11:20 a.m., Resident #8 was in a wheelchair with a lap buddy across her abdomen. The vinyl covering of the lap buddy was observed with three torn areas exposing a white foam interior.</p> <p>3.1-19(bb)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to position</p>			F0315	<p>The corrective action accomplished for the residents found to have been affected by the deficient practice is inservicing of staff on foley</p>		05/18/2011

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>and maintain a urinary drainage catheter in a manner to prevent back flow and potential for infection for 1 of 2 residents reviewed in a sample of 12. [Resident #41]</p> <p>Finding includes:</p> <p>On 4/5/11 at 3:15 p.m., CNAs #7 and #8 were observed to provide care and transfer Resident #41 from the bed to wheel chair with a mechanical lift. Resident #41 was observed with an indwelling Foley catheter. Amber colored urine was observed in the drainage bag and tubing.</p> <p>While positioning a sling under the resident, CNA #8 placed the urinary drainage on the mattress, next the resident. CNA #8 then raised the</p>				<p>catheter care/placement. Residents having the potential to be affected by the same deficient practice are identified as those resident with a foley catheter. (4) Measures put into place to make sure the deficient practice does not recur is inservicing staff on proper catheter care and checking off each nursing staff member for knowledge of proper catheter placement. The charge nurses and DON will monitor the corrective action by observations daily of catheter care/placement with documentation on flow sheets. Daily observations to be done for 30 days, then weekly for 30 days. DON will review infection control log monthly for increase in UTI with foleys.</p>		

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	<p>drainage bag and tubing, holding it above the resident lying in bed, while CNA #7 exited the room to retrieve an item.</p> <p>Resident #41's clinical record was reviewed on 4/6/11 at 3:30 p.m. The most recent Minimum Data Set [MDS] assessment, completed on 1/25/11 coded the resident as utilizing a Foley catheter. A physician's order was noted dated 3/4/11 for an antibiotic to treat a urinary tract infection.</p> <p>A facility policy titled "Foley Catheter Care," [no date] provided by the DON on 4/7/11 at 10:35 a.m., included, but was not limited to, "8. Drainage bag must not be raised higher than the knees or bladder."</p>						

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F0322 SS=D	During interview on 4/8/11 at 4:30 p.m., the SSD indicated CNA #8 had indicated to her after the observation that he knew he should not have raised the catheter bag and tubing above the resident's bladder level.  3.1-41(a)(2)						
	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  Based on observation and record review, the facility failed to ensure services to prevent aspiration pneumonia for 1 of 1 resident reviewed receiving medication through a			F0322	The corrective action accomplished for the resident found to have been affected by the deficient practice is inservicing of nursing personnel regarding having the head of bed up at least 30 degrees on residents with g-tube feedings. Residents identified having the potential to be affected		05/18/2011

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>gastrostomy tube in a sample of 12, in that medication and water flushes were observed to be given while the resident was lying flat in bed. (Resident #3)</p> <p>Finding includes:</p> <p>During medication pass on 4/6/11 at 2 p.m., LPN #3 provided medication and water flushes through a gastrostomy tube to Resident #3. The resident was lying in bed. The head of the bed was flat. During the medication and water flushes the resident would sit partially up but at times was lying flat in the bed. The LPN did not attempt to keep the resident's upper body positioned 30 degrees or higher.</p> <p>During review of the facility</p>				<p>by this deficiency are residents with g-tubes. (1) Measures put into place to make sure the deficient practice does not recur is inservicing staff on g-tube policy which includes having head of bed up. For this resident, the head of her bed has been raised 30 degrees and is in a permanent fixed position. Also, policy and care plan have been changed to reflect 30 degrees instead of 45 degrees, as 30 is much more comfortable for resident. The corrective action will be monitored by the charge nurses with daily documentation on the Medication Administration Record under "HOB raised at least 30 degrees". DON will monitor the MAR monthly for the documentation.</p>		

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F0323 SS=E	<p>policy and procedure, titled "Administration of Medication Through G-Tube" received and identified as a current policy from the DON (Director of Nursing) on 4/7/11 at 10:30 a.m., documentation indicated, but was not limited to, "Place resident in proper position" and "a. If resident is in bed, elevate head of bed to 45 degrees."</p> <p>3.1-44(a)(2)</p>			F0323			05/18/2011
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to prevent accidents and/or potential accidents for 3 of 3 residents reviewed either utilizing mechanical lifts and/or having</p>				<p>1. The electric hoier lift that was bent was removed from facility on 4/5/2011 and a new electric hoier lift was purchased and in the facility on 4/5/2011. Maintenance to inspect the lift per manufacturer's recommendations and should anything be found to be unsatisfactory, the lift will not be used. Facility has a back-up manual lift.3 and 4: The corrective action accomplished for this deficiency is inservice on</p>		

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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN47433			
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	<p>an incident during the use of a mechanical lift (Residents #'s 21, 41, and 42) and 1 of 1 resident utilizing a lap belt restraint (Resident #34) in a sample of 12, in that manufacturers' recommendations were not followed during use of mechanical lifts and/or a lift was utilized after the structure had been impaired. This had the potential to affect 11 of 11 residents utilizing mechanical lifts; and manufacturer's recommendations for application of a soft belt restraint were not followed for 1 of 1 resident reviewed in a sample of 12 utilizing the device. (Resident #34)</p> <p>Findings include:</p> <p>1. During initial tour on 4/4/11</p>				<p>nursing staff on correct use of lift. Residents identified as having the potential to be affected by the deficient practice are those residents requiring use of hooyer lift for transfers. (11) Practices put into place to ensure the deficient practice does not recur includes the inservicing of nursing staff on proper use of hooyer lifts. Each staff member will be checked off on proper use of lift. Charge nurses shall be responsible for monitoring the use of the hooyer lifts on their shifts. They shall daily pick one transfer to monitor and document observations on a flow sheet. This shall be daily times one month, weekly times 2 months, and monthly times 3 months. Findings shall be reported to the DON and administrator. 2. The corrective action accomplished for this deficiency is inservicing of nursing staff on correct application of lap restraint. Residents having the potential to be affected by the deficient practice are those residents with orders for lap restraints. Currently there are no residents with orders for lap restraint as order for lap belt for resident #34 has been dc'd. To ensure the deficient practice does not recur is the inservicing of staff on proper application of lap restraints. Should an order be obtained for a resident to have a lap restraint, the charge nurse shall monitor daily for proper</p>		

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	<p>which began at 12:15 p.m., with LPN#6, an Invacare mechanical lift was noted in the hallway with a sign indicating not to use the lift.</p> <p>During interview on 4/5/11, with LPN #6, which began at 11:30 a.m., LPN #6 indicated there had been an incident with the lift on Sunday, 4/3/11. The LPN indicated the lift had tipped over during the transfer of Resident #21.</p> <p>During interview of the DON (Director of Nursing) on 4/5/11 at 12:15 p.m., the DON indicated CNA #'s 2 and 7 were the CNAs transferring Resident #21.</p> <p>During interview of CNA #2, on 4/5/11 at 12:30 p.m., the CNA indicated the main mast</p>				application and document on a flow sheet findings.		

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	<p>of the Invacare lift being used to transfer Resident #21 on 4/3/11, was bent. The CNA indicated the lift had been bent for a few months.</p> <p>During interview of CNA #7, on 4/7/11 at 2:20 p.m., the CNA indicated the Invacare lift mast was bent toward the left, and the lift tipped over toward the left. The CNA indicated the resident had not been hurt, as the resident grabbed a cushion out of the wheelchair and landed on the cushion with her buttocks and the resident's arms and legs were straight out. The CNA indicated the lift was sent out, but when returned the mast was still bent. The CNA indicated the maintenance supervisor indicated the lift was safe to use.</p>						

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	<p>During interview of LPN #3 on 4/5/11 at 12:50 p.m., the LPN indicated the staff knew the lift had a bent mast. The LPN indicated, the lift had been used to lift Resident #40 off the floor and that was when the lift was damaged. The LPN indicated she thought they had sent the lift out to be fixed and when the lift was returned, they were told the lift was safe to be used. The LPN indicated the mast of the lift on return was still bent.</p> <p>During interview of the Maintenance supervisor on 4/7/11 at 11:45 a.m., the maintenance person indicated the lift had been sent to a welding company in order to have the mast straighten. The maintenance person indicated the lift had been returned to the</p>						

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	<p>facility on 2/11/11. The maintenance supervisor indicated he checked the mechanical lifts at least two times a month, checking and tightening bolts and lubricating as needed.</p> <p>During interview of the DON on 4/6/11 at 11 a.m., the DON indicated the mast of the lift was just bent a little bit. The DON indicated she was not sure what was done to the lift when sent out, but she and the staff were told it was ok to use the lift, when the lift was returned to the facility. The DON indicated the facility had a Hoyer and Invacare mechanical lift and the lifts had been used interchangeably for residents needing a mechanical lift.</p>						

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	<p>On 4/6/11 at 11:15 a.m., the DON provided a list of 11 residents names, that required a mechanical lift for transfers, and would have used either the Hoyer Lift or the Invacare Lift since the lift was returned to the facility on 2/22/11. During interview at that time, The DON indicated there had not been any other incidents with the lift after the lift was returned to the facility on 2/22/11, until 4/3/11, when the lift tipped over during the transfer of Resident #21. The DON indicated Resident #21 had not been injured.</p> <p>During review of Resident #21's clinical record, a nurse's note, dated 4/3/11, at 3:15 p.m., indicated during a transfer of the resident the mechanical lift tipped over. Documentation</p>						

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	<p>indicated "Denies hitting head, denies any pain or discomfort just scared. Wants to go smoke."</p> <p>Diagnoses was noted of, but not limited to, Dementia with behaviors and history of a CVA (cerebral vascular accident) with left sided hemiplegia.</p> <p>2. On 4/4/11 at 12 noon, and 4/6/11 at 4:45 p.m., Resident #34 was sitting in a wheelchair with a lap belt restraint. The belt was across the resident's abdomen, and the straps of the belt went straight back, across the top of the arms of the wheelchair, and was tied at the chair back of the wheelchair.</p> <p>During review of "POSEY - APPLICATION INSTRUCTION SHEET</p>						

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	<p>POSEY LAP BELT/PADDED LAP BELT" received by the DON on 4/7/11 at 10:40 a.m., documentation indicated "1. Lay the belt across the patient's lap, foam side down. 2. Bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard. 3. Go around the back post and cross the straps behind the patient. Secure the loops on the wheelchair tilt levers. The Belt should be over the patient's hip at a 45 degree angle holding the hips against the back of the chair...."</p> <p>3. On 4/5/11 at 10:45 a.m., CNA's # 4 and 5 transferred Resident #42 from the bed to a geri-chair utilizing a Hoyer mechanical lift. Prior to the transfer the staff did not lock the wheels of the geri-chair and</p>						

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	<p>while attempting to lower the resident into the geri-chair, the geri-chair rolled backward.</p> <p>During review of "How to use a Hoyer Lift/ Proper use of Hoyer Lift/Hoyer Lift Safety Instruction" on 4/7/11 at 10:35 a.m., provided by the DON, documentation indicated "Grasp steering handles and move lifter away from the bed. Move patient into position over the seat of wheelchair. Make sure wheelchair brakes are on."</p> <p>4. On 4/5/11 at 3:15 p.m., CNAs #7 and #8 were observed to transfer Resident #41 from the bed to wheelchair with the Invacare Reliant 450 mechanical lift. The base of the lift was positioned under the resident's bed and the lift sling attached to the lift. The resident was raised several inches above the surface of the bed. With the resident in the raised position, perpendicular to the mast, the base was moved away from the bed and transferred to the other side of the room. The base of the lift was opened around the resident's</p>						

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	wheelchair, and the resident lowered into the chair.  Review of the manufacturer's guidelines for the Invacare Reliant 450 on 4/08/11 at 2:30 p.m. indicated the following: "...ONLY operate this lift with the legs in MAXIMUM OPEN POSITION and LOCKED in place. The base legs MUST be locked in the open position at all times for stability and patient safety when lifting and transferring a patient...5. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the lift procedure. 6. Press the DOWN button (electric) or open the control valve (manual/hydraulic) lowering patient so that his feet rest on the base of the lift, straddling the mast...NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to move.  3.1-41(a)(2)						

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F0334 SS=C	<p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes</p>						

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	<p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure 1) residents and/or legal representatives were provided education of the benefits before offering the influenza immunization and 2) each resident's clinical record included documentation that the resident and/or residents' legal representatives were provided the benefits of the Influenza immunization for 9 of 11 residents in a sample of</p>			F0334	<p>The correction action accomplished for this deficiency is that a new form will be developed that will include the benefits of receiving the flu vaccine and will be maintained on the chart of each resident in the facility after signing by the resident or representative yearly before the flu vaccine is given each year. Residents having the potential to be affected by the deficient practice include all residents of the facility. Steps to be taken to correct the deficient practice are that a new form will be developed or located that will have not only the adverse reactions of receiving the flu vaccine, but also the benefits of receiving the vaccine. The form shall be given or sent to each resident and/or representative</p>		05/18/2011

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	<p>12 identified as receiving or refusing the influenza immunization. [Resident #'s' 18, 42, 15, 30, 41, 27, 14, 3, and 40]</p> <p>Findings include:</p> <p>1. Resident 18's clinical record was reviewed on 4/4/11 at 2:15 p.m.</p> <p>Documentation indicated the resident received a influenza vaccine on 11/10/10.</p> <p>Information regarding the benefits of influenza immunization was lacking.</p> <p>2. Resident #42 's clinical record was reviewed on 4/6/11 at 10:25 a.m.</p>				<p>before the flu season begins and vaccines are administered. Should a representative not return the form in a timely manner, the DON or designee shall call the representative and document a verbal agreement or refusal for the flu vaccine. The DON shall be responsible for monitoring the system. Permission forms shall be sent out in Aug/Sept of each year. DON or designee shall review each chart for the signed form before the flu vaccine is administered.</p>		

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	<p>Documentation indicated the resident received a influenza vaccine on 11/10/10.</p> <p>Information regarding the benefits of influenza immunization was lacking.</p> <p>3. Resident #15's clinical record was reviewed on 4/7/11 at 12:25 a.m.</p> <p>Documentation indicated the resident received a influenza vaccine on 11/10/10.</p> <p>Information regarding the benefits of influenza immunization was lacking.</p> <p>4. Resident #30's clinical record was reviewed on 4/7/11 at 1:40 p.m.</p>						

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	<p>Documentation indicated the resident received a influenza vaccine on 11/10/10.</p> <p>Information regarding the benefits of influenza immunization was lacking.</p> <p>5. Resident #41's clinical record was reviewed on 4/6/11 at 3:30 p.m. Documentation was noted of the resident receiving the flu vaccine on 11/10/11. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on the medical record was lacking.</p> <p>6. Resident #27's clinical record was reviewed on 4/8/11 at 12:15 p.m. Documentation was noted of the resident receiving the flu vaccine on 11/10/11. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on the medical record was lacking.</p>						

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	<p>7. Resident #14's clinical record was reviewed on 4/7/11 at 12:15 p.m. Documentation was noted of the resident receiving the flu vaccine on 11/10/11. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on the medical record was lacking.</p> <p>8. Resident #3's clinical record was reviewed on 4/4/11 at 2:30 p.m. Documentation was noted of the resident receiving the flu vaccine on 11/10/11. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on</p>						

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	<p>the medical record was lacking.</p> <p>9. Resident #40's clinical record was reviewed on 4/8/11 at 11:45 a.m. Documentation was noted of the resident receiving the flu vaccine on 11/10/11. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on the medical record was lacking.</p> <p>The DON was interviewed on 4/8/11 at 3:00 p.m. The DON indicated the information regarding the benefits of the influenza immunizations had not been provided to the residents or their representative.</p>						

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F0365 SS=D	<p>3.1-13(a)</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received food designed to meet their needs for 1 of 2 residents reviewed requiring thickener due to swallowing problems, in that the resident was receiving different consistencies of food and drink. (Resident #42)</p> <p>Finding includes:</p> <p>During observation on 4/6/11 at 11:40 p.m., CNA #4 was feeding and providing fluids to</p>			F0365	<p>The corrective action accomplished for this deficiency will be inservicing of nursing staff on different thickened consistencies: honey, nectar, and pudding. Those residents identified as having the potential to be affected by the deficient practice are those residents with an order for thickener. (4) The steps to ensure this deficient practice does not occur again, include: inservicing nursing staff on difference of thickened liquids: honey, nectar, and pudding, and how much thickener to use for each type of thickened liquids. Orders for these 4 residents have been reviewed and the consistency of the thickened liquids has been addressed in the orders, dietary tray cards, and care plans. The charge nurses and DON will observe at mealtime for the correct consistency of the thickened fluids. Documentation will be made on a flow sheet for</p>		05/18/2011

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	<p>Resident #42. The resident received a pureed diet. Two medication cups, half full of a white substance, were noted on the food tray. CNA #4 was observed to be sprinkling the white substance in the meat puree, and placing small amounts in the resident's water. The resident dietary card on the food tray indicated "thickener", but did not specify the consistency.</p> <p>During interview with CNA #4 on 4/6/11 at 11:40 a.m., the CNA indicated the substance in the medication cup was thickener. The CNA indicated the resident just needs a little thickener. The resident's water was observed to be given to the resident with a glass and the resident was able to swallow the liquid. The liquid appeared</p>				<p>each resident. Observations will be done at lunch and supper daily times 2 months, weekly for 2 months, then monthly for 2 months.</p>		

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	<p>to be thin. The CNA was unsure the type of consistency the resident's fluids were to be.</p> <p>On 4/6/11 at 4:45 p.m., CNA #16 was feeding Resident #42. The resident's fluids were observed to be very thick and the resident was spoon fed the liquids.</p> <p>During interview of CNA #16, on 4/6/11 at 4:45 p.m., the CNA indicated Dietary put two 1/2 full medication cups of thickener. The CNA indicated she put the thickener in two glasses of fluid. The CNA was unable to identify the type of thickened liquids the resident was to receive.</p> <p>Resident #42's clinical record was reviewed on 4/6/11 at 10:25 a.m.</p>						

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	<p>The most recent physician update orders were dated 4/1/11.</p> <p>A physician order was noted of "Pureed NCS [no concentrated sweets], Honey thicken liquids."</p> <p>A plan of care was noted, with an onset date of 10/18/07, with a target date of 3/20/11, indicating "At risk for choking D/T [due to] chewing /swallowing problems, with an approach of "Diet as ordered-pureed diet with thickened liquids."</p> <p>On 4/7/11 at 2 p.m., the DON (Director of Nursing) provided information concerning the type of "THICK IT" used by the facility. The</p>						

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	<p>documentation indicated for "Honey-Like" thickness, based on a 4 oz single serving, that 3-5 tsp [teaspoons] should be added. Further documentation indicated the thickener would thicken a variety of hot or cold liquids to the viscosity standards of the National Dysphasia Diet and the natural viscosity of the liquid being thickened and its serving temperature impact the amount of Thick-it Food Thickener required.</p> <p>During interview of the DON on 4/7/11 at 2:00 p.m., the DON indicated when an order is received for a change in the resident's diet, the dietary department receives the information. The DON indicated the dietary department sends out thickener</p>						

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F0367 SS=D	<p>for the staff to utilize if the resident requires thickener.</p> <p>3.1-21(a)(3)</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>Based on observation, interview, and record review, the facility failed to ensure thickened liquids for 1 of 2 residents reviewed in a sample of 12 with thickened liquids had a physician's order for the thickened form. [Resident #3]</p> <p>Finding includes:</p> <p>On 4/6/11 at 5:00 p.m., Resident #3 was observed in the dining room being fed by LPN #12. The resident was observed to have a glass of grape juice, water, and milk. A small plastic cup, identified by</p>			F0367	<p>The corrective action accomplished for this resident is that physician was notified and order was received for pudding thickened liquids. Resident's identified as having the potential to be affected by the same deficiency are all residents of the facility. The steps taken to prevent the deficiency from occurring again is that on April 28 and 29, the DON audited all resident physician orders for missing or incorrect orders. The physician was notified of any incorrect or missing orders and orders were obtained. DON will be responsible for monitoring the orders for correct/missing orders monthly when the new orders arrive for the coming month and will notify MD as needed. Any orders needing corrected or added will be documented and discussed at the monthly QA meeting.</p>		05/18/2011

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	<p>LPN #12 as thickener was observed on the resident's meal tray. LPN #12 indicated one half of the thickener was put into the grape juice and one half into the water.</p> <p>On 4/6/11 at 5:15 a.m. the DON was interviewed and observed the resident's liquids. The DON indicated the resident's liquids were thickened to pudding consistency. The DON indicated the resident's husband did not want the resident to have any swallow studies and resident had increased difficulties with liquids due to diagnosis of Huntington's Chorea.</p> <p>Resident #3's clinical record was reviewed on 4/4/11 at 2:30 p.m. The most recent</p>						

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	<p>recapitulation, signed by the physician on 4/1/11 did not include an order for pudding thickened liquids.</p> <p>A plan of care, with most recent update of 11/2/10 addressed the problem of "Needs adequate nutrition to aid in improving weight and CBC [complete blood count] Approaches included, but were not limited to, "Feed resident and monitor for choking/aspiration, feed in small bites only. Thicken liquids to pudding consistency and spoon feed to resident."</p> <p>The DON was interviewed on 4/7/11 at 3:10 p.m. the DON indicated a physician's order for pudding thickened liquids was lacking.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2011

FORM APPROVED

OMB NO. 0938-0391

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	3.1-21(b)						

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure hand hygiene</p>			F0441	<p>The corrective action accomplished for those residents found to have been affected by the deficient practice includes inservicing of staff on handwashing and infection</p>		05/18/2011

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	<p>for 1 of 2 observations of urinary catheter handling [Resident #41]; and 1 of 1 observation of incontinence care [Resident #3] in that CNAs #1, #7, and #8 failed to remove gloves after handling contaminated services and before touching other items in a sample of 12.</p> <p>Findings include:</p> <p>1. On 4/5/11 at 11:20 a.m., CNAs #1 and #2 were observed to provide incontinence care to Resident #3. While wearing gloves, the CNAs removed the residents soiled brief and slacks. CNA #1 sprayed a wash cloth with cleanser from a multiple use bottle, and cleansed the resident's peri-area and inner thighs. and assisted the resident to sit in a</p>				<p>control. All residents of the facility have the potential to be affected by the same deficient practice. Measures put into place to ensure that the deficient practice does not recur include inservicing of staff with a demonstration of handwashing/infection control practices for nursing staff. The corrective action will be monitored by the charge nurses and DON with daily observations for 30 days of handwashing techniques. DON will also monitor the infection control log monthly for increase of infections to residents. Findings will be reviewed at the monthly QA meetings.</p>		

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	<p>wheelchair. The CNA, while wearing the same gloves, wet another wash cloth, picking up the bottle of cleanser assisted the resident to stand and cleansed the resident's buttocks. CNA #1 then picked up a multiple use tube of barrier cream, while wearing the same gloves, and applied the cream to the resident's buttocks. The CNA then assisted in pulling up a clean brief and slacks, removed the gloves and positioned a lap buddy to the resident's wheelchair. CNA #1 picked up the tube of cream and bottle of spray cleanser, exited the room, carried the items into the dining room, to the West nursing unit, and entered utility room with the items.</p> <p>2. On 4/5/11 at 3:15 p.m.,</p>						

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	<p>CNAs #7 and #8 were observed to provide ADL (activities of daily living) care to Resident #41. The resident was observed in bed and to have a Foley catheter. Without wearing gloves, CNA #8 picked up the urinary drainage bag, handled the catheter tubing, laid the drainage bag on the resident's bed, opened the window and adjusted the window blinds in the resident's room, without washing hands.</p> <p>The facility's policy titled "Handwashing Procedure," [no date] provided by the DON on 4/7/11 at 10:35 a.m., included but was not limited to: "Handwashing is the single most important means of preventing the spread of infection! ...Hands are to be washed: 3. After handling</p>						

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F0456 SS=D	<p>bedpans, catheters, linens, etc. ...The purpose of handwashing for general resident care is to remove potentially pathogenic organisms. Those organisms can have many different sources; organisms from ...infected urine, picked up during routine emptying of a catheter bag may be deposited on the next resident's catheter bag and may cause infection. ..."</p> <p>3.1-18(l)</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure resident equipment was maintained in that 2 of 2 geri-chairs and 2 of 3 lap</p>			F0456	<p>The corrective action accomplished for this deficiency is that 2 new geri-chairs and 3 lap buddies will be ordered to replace the damaged ones. Those residents having the potential to be affected by the deficient practice are identified as those residents who use a geri-chair or</p>		05/18/2011

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	<p>buddies observed were either ripped or had bent frames. [Residents #9, #42, and #8]</p> <p>Findings include:</p> <p>1. During environmental tour with the Maintenance staff #15 on 4/8/11 at 11:00 a.m. Resident #9's geri-chair was observed with a crooked foot rest. The Maintenance person looked under the chair and during interview at that time, indicated the metal frame to the foot rest was bent. On 4/4/11 at 12:00 p.m., Resident #9 was observed in the chair, in the dining room, and for the footrest to be slanting to the right.</p> <p>2. During observation of care on 4/5/11 at 10:20 p.m., Resident #42 was placed in a</p>				<p>lap buddy.Measures put into place to ensure the deficient practice does not recur is staff will be inserviced on monitoring geri-chairs and lap buddies for wear and damage and how to report to maintenance if repairs are needed. Maintenance will inspect geri-chairs weekly and document findings and report to administrator when repairs/replacements are needed.Administrator will be responsible for geri-chair replacement/repairs and DON will be responsible for replacement of damaged lap buddies</p>		

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	<p>geri-chair. The foot rest of the chair was observed to be crooked and when in a down position would not close all the way. The vinyl was torn on one corner of the seat cushion, exposing a white foam interior. Heavy dust was noted on the interior back base of the geri-chair.</p> <p>3. On 4/6/11 at 11:20 a.m., Resident #8 was in a wheelchair with a lap buddy across her abdomen. The vinyl covering of the lap buddy was observed with three torn areas exposing a white foam interior.</p> <p>3.1-19(bb)</p>						